many writers have found a close alliance between genius and madness. Threat to personality was felt acutely by that abnormal man and many-sided genius Leonardo da Vinci, who wrote that to create he must be solitary: "While you are alone you are entirely your own, and if you have one companion you are half your own." It is hard, even for the man of genius, to remain out of the herd and at the same time show signs and symptoms of behaviour that the herd dubs normal. This anarchic tendency of his mind may progress so far that, like van Gogh, he may eventually find himself in an asylum in the company of other solitaries who, apart from their similarity to him in madness, differ completely in the commonplace nature of their achievements. It would seem that literary and artistic genius flourish in a society that is stable and prosperous, and wilt in a society that is unstable—another theme, perhaps, for Dr. Russell Brain to explore for our entertainment and delight.

A RITUAL OPERATION

Little is known of the origin of circumcision, despite the very considerable literature on the subject.[1] At its inception the practice seems to have had an essentially religious connotation and to have arisen independently in the continents of Africa, America, and Australia. Among the Semitic races it is probable that circumcision started as an act of consecration to the goddess of fertility with the object of winning her favour and thus ensuring the birth of children. Circumcision in ancient Egypt was certainly not undertaken for hygienic reasons, and probably it served as a sanctification of the reproductive faculties and a ceremonial initiation. It is likely that the ancient Pharaohs were circumcised, the circumcised state being a necessary qualification for the priesthood. It is reported that Pythagoras had himself circumcised while in Egypt so that he might be fully initiated into the esoteric religious rites of the Egyptians. Among others, notably the American Indians, circumcision was mainly adopted as an alternative to human sacrifice. Although circumcision is widespread in Moslem communities the Koran contains no specific ordinance on this subject. Mohammed is said to have been born without a prepuce, and the possession of a foreskin was regarded as a disgrace amongst the Arabs. It is reported that after one of the Prophet's battles a slain Thaqafite tribesman was found uncircumcised, and great pains were taken to prove that he was a Christian and not truly a member of the tribe. In Arab communities the operation is performed with scissors, a razor, or a split reed, and there is a tradition that Abraham used an axe and was rebuked for his haste.

[1] Hastings, J., *Encyclopaedia of Religion and Ethics*, 1910, vol. 3, Edinburgh.
[2] Kennaway, E. L., *Brit. J. Cancer*, 1947, 1, 335.
[3] Ibid., 1948, 2, 177.

Some of the methods of disposal of the foreskin are more a matter for interest than emulation. The Levites during the Exodus piled their foreskins in the wilderness and covered them with earth; in parts of West Africa, where the operation is performed at about 8 years of age, the prepuce is dipped in brandy and eaten by the patient; in other districts the operator is enjoined to consume the fruits of his handiwork, and yet a further practice, in Madagascar, is to wrap the operation specimen in a banana leaf and feed it to a calf. In happy contrast to some of these macabre practices is the habit of the Bani Chams in Australia, who merely perform a mock ceremony with a wooden knife and leave their victims unscathed.

In Britain, while the practice of circumcision is widespread, there are rather different reasons for its performance, and, though exact figures are difficult to obtain, it would seem that more than half the male members of the population are circumcised. Many doctors have for long rebelled against the wholesale and somewhat primitive lopping of the infant foreskin which goes on in some out-patient departments and surgeries. On these occasions the technique of the operation is frequently deplorable; sacrifice of skin is often too generous, and attendant damage to the glans penis or fraenum is not unknown. If these criticisms are valid then it may well be asked why large numbers of doctors permit and encourage a practice which so savours of the barbaric. Religious considerations apart, it is not easy to find a rational argument for circumcision in most cases, and the operation is more often performed because it is *de rigueur* in certain districts or a habit in some families.

Dr. Douglas Gairdner's valuable study, "The Fate of the Foreskin," which appears at page 1433 in this issue, will, we believe, make many readers pause for reflection. Though medical opinion about circumcision may be more conservative than it used to be, yet even to-day the attitude of the profession in general to the subject is too often based upon false ideas of the anatomy and physiology of what is a useful cutaneous appendage. Of the value of the prepuce in the first two or three years of life there is no doubt, for it has an important function in covering and protecting the glans penis. Contrary to widespread belief, non-retractability, a frequent finding, is not synonymous with phimosis. There can be little medical justification for routine circumcision of the infant, and the operation is only occasionally necessary under the age of 3. After this age operation is indicated for cases of non-retractability with true phimosis and for those with recurrent preputial inflammation or paraphimosis. Circumcision should be limited in extent: the fraenal region must not be damaged, and sufficient skin must be left to cover the very sensitive corona glandis. Although the operation of dorsal slit is unpopular with

some, it is both satisfactory and simple to perform, and the ultimate cosmetic result is good.

Apart from the local reasons for circumcision it is argued by some that it will reduce the incidence of venereal disease, cancer of the penis, and cancer of the cervix uteri. The evidence supporting the first of these contentions is inconclusive; the second is established beyond doubt; while the available data on cancer of the cervix do not warrant the conclusions which have been drawn by some authorities. As Dr. Gairdner points out, it is likely that lack of cleanliness is more important than lack of circumcision in the case of venereal diseases and cancer of the penis. If the latter was not a very uncommon disease in this country it alone might provide justification for widespread emulation of the Jewish custom. The Mosaic law enjoins the practice of circumcision on the eighth day, and it appears certain that this ritual circumcision affords complete protection against carcinoma of the penis. Furthermore it has been shown that circumcision between the third and fourteenth years of life does not give complete protection against penile carcinoma.[2] In the absence of more convincing evidence about carcinoma of the cervix it is difficult to ascribe its low incidence in Jewesses to the circumcision of their spouses. As Kennaway[3] has pointed out, the data are inadequate, and the low incidence in certain other races cannot be explained by the practice of circumcision. It seems safe to say that if Dr. Gairdner's recommendations are accepted much circumcisional morbidity and mortality will be avoided and, further, that there is no good reason to fear increased incidence of venereal disease or genital cancer as a result of this policy.

RADIOLOGY IN OBSTETRICS

The technical difficulties of obstetric radiography have prevented it from being so generally accepted as radiography in such other fields as the diagnosis of fractures or of diseases of the chest. At this year's Annual Meeting of the British Medical Association in Harrogate there was an interesting discussion in the Section of Obstetrics and Gynaecology on radiology in obstetrics, and two of the papers contributed to that discussion appear in the present issue of the *Journal*.

Professor J. Chassar Moir, describing the use of radiographs for assessing disproportion, begins with a plea for closer co-operation between the radiologist and the obstetrician. He himself has set the excellent example of being his own radiologist, but this happy combination is a rare one, since few obstetricians have the aptitude, training, or indeed the time to master the difficult and exacting technique of pelvic radiography. Professor Moir is the first to recognize the limitations of the method. It can give no more than a mechanistic picture of cephalo-pelvic disproportion, and it cannot measure such other factors as the efficiency of the uterine muscle or the mouldability of the foetal head. Nevertheless, mechanical difficulty remains the commonest cause of dystocia, and in skilled hands the radiographic method of measuring both the maternal pelvis and the foetal skull can achieve an accuracy far superior to anything that can be achieved by clinical means. There are probably two reasons why this method has not received universal acceptance as an essential part of obstetrical diagnosis—first because inaccurate measurement is all too easy in the absence of adequate skill and experience, and secondly because equipment for this type of radiography has not yet been used sufficiently widely for the method to have became a routine diagnostic procedure. Professor Moir makes the point that pelvic shape is at least as important as pelvic size, and the traditional measurement of the true conjugate may be of little value unless the other diameters of the pelvis are taken into account. Here radiography is of the greatest value, since it is the only means by which an accurate measurement can be obtained of the transverse diameter of the pelvic brim or by which a true picture of the shape of the pelvis can be obtained in the living subject. Pelvic size and shape, however, must be considered in relation to the measurement of the foetal skull in assessing disproportion. Most of the recent work on pelvic radiography has been concerned with these two factors, and many ingenious methods of relating them have been described. Professor Moir has devised three charts—for the brim, cavity, and outlet—from which an impression can be gained about the level at which difficulty may be expected with different sizes of foetal head. By this means he has succeeded not only in predicting difficulty in labour but also in indicating the cases in which an easy and rapid labour can be confidently expected. Obstetric radiography has tended to diminish rather than to increase the use of caesarean section, since in many cases where clinical examination appeared to reveal disproportion radiography has shown that, even when the pelvis was contracted, vaginal delivery was possible because the baby was small.

Measurement of the maternal pelvis can, on the whole, be made with more accuracy than measurement of the foetal skull. Dr. S. Josephs, in the second paper on this subject, discusses the intrauterine measurement of the foetal biparietal diameter. The accuracy of these measurements was checked after delivery of the child by independent observers who had no knowledge of the previous readings. Dr. Josephs does not give details of the actual method employed, but the results are impressive. The radiological method tended to overestimate the size of the head by 0.02 in. (0.5 mm.), but in the whole series it was found possible to predict the size of the biparietal